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Health Status and the Worlds of Welfare

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One of the most substantial additions made by the 'three worlds of welfare' thesis to the welfare state modelling business is that comparisons should examine what welfare states actually do rather than how much they are afforded or which services they provide. This paper extends this basic principle by comparing the health outcomes (measured in terms of infant mortality rates) of welfare states and welfare state regimes. It examines whether there are significant differences in health status between the 'three worlds of welfare' and to what extent a relationship exists between health and decommodification. It concludes by reflecting upon the implications for the 'three worlds of welfare'.

Introduction

How we classify welfare states has long been a concern in social policy (Wilensky and Lebaux, 1958; Titmuss, 1974; Therborn, 1987; Esping-Andersen, 1990; Castles and Mitchell, 1993). Recently, the literature has been dominated by Esping-Andersen's 'three worlds of welfare' typology and the intensive academic debate that has surrounded it (Esping-Andersen, 1990; 1999; Lewis, 1992; Leibfreid, 1992; Castles and Mitchell, 1993; Orloff, 1993; Borchost, 1994; Daly, 1994; Kangas, 1994; Ragin, 1994; Ferrera, 1996; Shalev, 1996; Bonoli, 1997; Albrahamson, 1999; Goodin *et al.*, 1999; Sainsbury, 1999; Pitruzzello, 1999; Arts and Gelissen, 2002; Kasza, 2002; Bamba, 2004a; 2004b; 2005a, 2005b, 2006).

In *The Three Worlds of Welfare Capitalism* (1990: 52), Esping-Andersen presents a decommodification typology of welfare states: Liberal, Conservative, and Social Democratic. In the welfare states of the liberal regime (UK, USA, Ireland, Canada, Australia), state provision of welfare is minimal, benefits are modest and often attract strict entitlement criteria; and recipients are usually means-tested and stigmatised (Esping-Andersen, 1990: 26). The conservative welfare state regime (Germany, France, Austria, Belgium, Italy and, to a lesser extent, the Netherlands) is distinguished by its 'status differentiating' welfare programmes in which benefits are often earnings related, administered through the employer; and geared towards maintaining existing social patterns. Provision in the 'third world of welfare', the social democratic (Nordic countries), is characterised by universal and comparatively generous benefits, a commitment to full employment and income protection; and a strongly interventionist state (1990: 28).

Five substantive critiques of this typology have emerged: the range of countries and number of regime types; the methodology used; the usefulness of the regime concept; the analytical dominance of income maintenance schemes over welfare services; and the omission of gender in the analysis. Leibfreid (1992), Ferrera (1996) and Bonoli (1997) assert that a distinctive fourth type of welfare state regime is emerging in the countries of the Latin rim of the European Union (Spain, Portugal, Greece and to a lesser extent Italy)

and Castles and Mitchell (1993) argue that the UK, Australia and New Zealand constitute another 'radical' fourth type of welfare state regime (Castles and Mitchell, 1993: 107). Esping-Andersen's methodology has been widely critiqued (Kangas, 1994; Ragin, 1994; Shalev, 1996; Fawcett and Papadopoulos, 1997; Pitruzzello, 1999; Bamba, 2006) and the use of cluster analysis has also suggested that there could be four or five 'worlds of welfare' (Pitruzzello, 1999: 23–50). Kasza (2002) has questioned the validity of the regimes concept itself, asserting that instead of internal policy homogeneity or cohesion, welfare states and welfare regimes exhibit significant variation across different areas of provision. Esping-Andersen's decision to organise the principle of classification around the study of cash benefit programs, ignoring the fact that welfare states are also about the actual delivery of services, has also been a source of contention (Abrahamson, 1999; Kautto, 2002). Feminist commentators (such as Lewis, 1992; Borchost, 1994; Daly, 1994; Sainsbury, 1994, 1999), have offered the most extensive critique, arguing that Esping-Andersen's 'three worlds of welfare' typology is deeply flawed because it marginalises women.

What is relatively undisputed though in this highly charged and prominent debate, is what is arguably the most substantial theoretical and empirical addition made by the 'three worlds of welfare' thesis to the welfare state modelling business – that comparisons should examine what welfare states actually do rather than how much they are afforded or which types of services they provide (Esping-Andersen, 1990: 2). However, instead of taking the principle of judging welfare states in terms of outputs rather than inputs, the comparative social policy literature has become bogged down in a 'settling of accounts with Esping-Andersen' (Pierson, 1998: 175). This paper attempts to refocus comparative social policy research by resurrecting and extending the basic principle that welfare states should be judged on what they do, through an empirical comparison of the health outcomes of welfare state regimes.

Esping-Andersen's thesis examined what welfare states do in terms of labour market decommodification, and other typologies have extended this principle by examining levels of income inequality (Korpi and Palmer, 1998), the decommodification of key welfare services (Bamba, 2005a, 2005b), or levels of defamilisation (Lewis, 1992; Orloff, 1993; Sainsbury, 1999; Korpi, 2000; Bamba, 2004a). Health, however, aside from the provision of health care services (Bamba, 2005a, 2005b), has been a notable omission from both the debate about the 'three worlds of welfare' and the wider welfare state modelling literature. This is very surprising, as it can also be used as a universal outcome indicator by which to judge, compare and categorise countries', or regimes', entire welfare state packages (Coburn, 2004). Health status, especially inequalities in health within and between Western countries, is largely considered to be determined by income inequalities, the distribution of wealth, and other aspects of social and class inequalities (Townsend *et al.* 1992; Wilkinson, 1996; Kawachi *et al.*, 1997; Mackenbach *et al.*, 1997; Acheson *et al.*, 1998). Welfare provision in its entirety (cash benefits and services) is designed to address these issues of inequality and should therefore have a bearing upon health outcomes (Bartley and Blane, 1997; Conley and Springer, 2001; Doran and Whitehead, 2003; Navarro *et al.*, 2003; Raphael and Bryant, 2004; Coburn, 2004).

Esping-Andersen's operationalisation of the concept of decommodification is in many ways a proxy measure of the overall welfare state provision provided by a country (although it only examines income maintenance programmes). Essentially, labour market decommodification relates to 'the extent to which individuals and families can maintain a

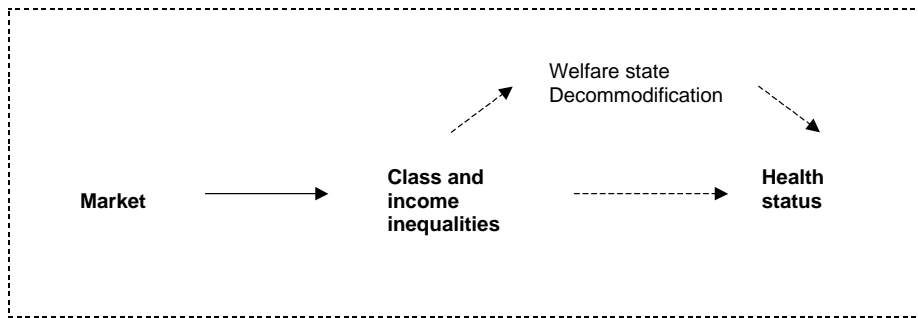


Figure 1. Decommodification and health status.

normal and socially acceptable standard of living regardless of their market performance' (Esping-Andersen, 1987: 86). Commodification, in contrast, refers to the extent to which workers and their families are reliant upon the market sale of their labour. The welfare state decommodified labour because certain services and a certain standard of living became a right of citizenship and reliance on the market for survival decreased (Esping-Andersen, 1990: 22).

In this way, welfare states, through their decommodifying effects, mediate the extent, and impact, of market derived class and income inequalities within a country (see Figure 1). Therefore, the decommodification provided by welfare states can be considered as a social determinant of health and can be expected to have an indirect relationship with health status (Raphael and Bryant, 2003): Countries with a highly decommodifying welfare state package will have less stark class and income inequalities (Esping-Andersen, 1990; 1999) and therefore better national health outcomes (Wilkinson, 1996) than those countries that operate a less decommodifying system (Coburn, 2004).

Two interrelated hypotheses develop from this discussion:

- (i) A relationship, albeit indirect, exists between labour market decommodification and health status.
- (ii) Labour market decommodification varies between welfare states and so their health status will also differ.

This paper compares how health status varies in 18 different welfare states in order to test these hypotheses and examine the wider implications for the 'three worlds of welfare' typology.

Methods

Labour market decommodification scores by country were taken from the decommodification indexes of Esping-Andersen (1990) and Bambra (2004b, 2005b). These indexes were based on the assessment of three income maintenance programmes: pensions, unemployment, and sickness. The process of scoring for each of the three programmes was by way of the numerical description of the relationship of an individual country's score to the mean (and standard deviation) for four of the five factors that make up each index. This score was weighted by a fifth factor – the population covered by the

program. Finally, the results of these three separate indexes, pensions, unemployment and sickness, were combined to give the overall decommodification score for each country. Comprehensive details of the scoring procedures are contained in Esping-Andersen (1990) and Bamba (2004b, 2005b).

The decommodification data were compared with infant mortality rates (IMR). IMR (deaths of babies under one year of age per 1000 live births) is a widely used comparative indicator of population health (Murray et al., 2000; Conley and Springer, 2001; Navarro et al., 2003; OECD, 2003; Reidpath and Allotey, 2003). It is considered as a highly sensitive measure because of the association between the causes of infant mortality and other factors, such as living conditions, social well being, rates of illness and economic status, that influence the health status of whole populations (Reidpath and Allotey, 2003). However, it is not without recognised problems (especially outside the countries of the West), not least the variation in how countries classify borderline cases such as barely viable foetuses (Howell and Blondell, 1994), or the fact that IMR is calculated from a small portion of the population (Reidpath and Allotey, 2003). IMRs have therefore recently been supplemented with various other measures of population health, such as disability-adjusted life expectancy – DALE, or health adjusted life expectancy – HALE (Murray et al., 2000). These newer measures are based on projections of life expectancy, adjusted for estimates of ill health or disability (WHO, 2000), and there is considerable debate as to their relative merits (see for example, Murray et al., 2000; WHO, 2000; Reidpath and Allotey, 2003). Furthermore, data are also only available on these newer measures for more recent years (post-1995) and so comparability over time is not possible. Therefore, as the debate over which of the new health measures is sufficient or better is beyond the remit of this paper, use of the traditional IMR measure, despite its drawbacks, will be maintained and it will be used as a proxy indicative measure of population level health. Indeed, IMR is strongly correlated ($r=0.91$) with DALE (Reidpath and Allotey, 2003) and with other population level health indicators such as premature death rates (WHO, 2000).

Decommodification data was only available for two separate years, 1980 (Esping-Andersen, 1990) and 1998 (Bamba, 2004b, 2005b), and for 18 OECD countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, UK, USA. Data relating to IMR were extracted from the Organisation for Economic Cooperation and Development Health Database (OECD, 2003) for the corresponding years and the corresponding 18 countries. All analysis was carried out using SPSS version 11.

Results

Table 1 shows the decommodification scores and IMRs for the individual 18 countries and the average decommodification scores and IMRs for each of the three welfare state regimes (Liberal, Conservative and Social Democratic). IMRs vary from 6.9 (Sweden) to 14.6 (Italy) in 1980 and from 3.5 (Sweden) to 7.2 (USA) in 1998. The IMRs of all of the countries decreased dramatically from an overall average of 11.2 in 1980 to an overall average of 5.6 in 1998. The decommodification scores are similarly varied with a range of 13 (Australia) to 39.1 (Sweden) in 1980 and from 11.5 (New Zealand) to 34.7 (Sweden) in 1998. The overall decommodification scores also moderately decreased between 1980 and 1998 from 27.2 to 25.7.

Table 1 IMRs¹ and decommodification scores² in the 'three worlds of welfare', 1980 and 1998

	Infant mortality rate ³ (deaths per 1000 live births)		Decommodification score	
	1980	1998	1980	1998
Liberal	12.3	6.7	18.8	17.4
Australia	10.7	5	13	13.5
Canada	10.4	5.3	22	27.9
Ireland	11.1	5.9	22.3	22.1
New Zealand	13	5.4	17.1	11.5
UK	12.1	5.7	23.4	15.4
USA	12.6	7.2	13.8	14
Conservative	10.5	4.5	29	28.2
Austria	14.3	4.9	31.1	31.1
Belgium	12.1	5.6	32.4	31.9
France	10	4.6	27.5	31.5
Germany	12.6	4.7	27.7	27.7
Italy	14.6	5.4	24.1	27.6
Japan	7.5	3.6	27.1	18.3
Netherlands	8.6	5.2	32.4	28
Switzerland	9.1	4.8	29.8	29.7
Social democratic	7.6	4.0	36.2	33.1
Denmark	8.4	4.7	38.1	29
Finland	7.6	4.2	29.2	34.6
Norway	8.1	3.9	38.3	34
Sweden	6.9	3.5	39.1	34.7

Notes: ¹ OECD (2003).

² Esping-Andersen (1990), Bamba (2004b, 2005b).

³ Regime rates are population weighted.

The Liberal regime had the highest IMR and the lowest labour market decommodification score in both 1980 and 1998 (Table 2). In 1980 the average IMR for the Liberal regime countries was 12.3, this fell to 6.7 in 1998. The Liberal countries' IMRs ranged from 10.4 (Canada) to 13 (New Zealand) in 1980 and from 5 (Australia) to 7.2 (USA) in 1998. The average decommodification score for the Liberal regime countries was 18.8 in 1980 and 17.4 in 1998. Individual labour market decommodification scores in the Liberal countries ranged from 13 (Australia) to 23.4 (UK) in 1980 and from 11.5 (New Zealand) to 27.9 (Canada) in 1998.

The Social Democratic regime had the lowest IMR and the highest labour market decommodification score in both 1980 and 1998 (Table 2). In 1980 the average IMR for the Social Democratic countries was 7.6 and in 1998 it was 4.0. The Social democratic countries' IMRs ranged from 6.9 (Sweden) to 8.4 (Denmark) in 1980 and from 3.5 (Sweden) to 4.7 (Denmark) in 1998. The Social democratic regime decommodification score was 36.2 in 1980 and 33.1 in 1998. Individual labour market decommodification scores in the Social Democratic countries ranged from 29.2 (Finland) to 39.1 (Sweden) in 1980 and from 29 (Denmark) to 34.7 (Sweden) in 1998.

Table 2 Difference between the 'three worlds of welfare' for IMR and decommodification

	IMR		Decommodification	
	1980	1998	1980	1998
Significance ¹	0.034	0.045	0.001	0.003

Note: ¹ P value ascertained by Kruskal–Wallis test for independent samples.

Table 3 Results for correlation¹ of IMRs with decommodification scores in 18 welfare states, 1980 and 1998

	IMR* decommodification	
	1980	1998
Spearman's r	−0.497	−0.585
r ²	0.247	0.342
Significance	0.005	0.018

Note: ¹ One-tailed bivariate Spearman's r correlation.

The Conservative regime had the median IMR and the median labour market decommodification score in both 1980 and 1998 (Table 2). In 1980 the Conservative IMR was 10.5 and this fell to 4.5 in 1998. The Conservative countries' IMRs ranged from 7.5 (Japan) to 14.6 (Italy) in 1980 and from 3.6 (Japan) to 5.6 (Belgium) in 1998. The Conservative regime's decommodification score was 29 in 1980 and 28.2 in 1998. Individual labour market decommodification scores in the Conservative countries ranged from 24.1 (Italy) to 32.4 (Italy and the Netherlands) in 1980 and from 18.3 (Japan) to 31.9 (Belgium) in 1998.

Table 2 shows that these differences between the three welfare state regimes, in terms of average IMR and average decommodification score, were statistically significant: infant mortality in the 'three worlds of welfare' differed significantly in 1980 ($p < 0.05$) and 1998 ($p < 0.05$); and labour market decommodification between the regimes also varied at a significant level in both 1980 ($p < 0.005$) and 1998 ($p < 0.005$). Table 3 shows that the relationship between IMRs and decommodification for the individual countries and the 'three worlds of welfare' (Liberal regime countries have high mortality and low decommodification, the Social Democratic regime countries have low infant mortality and high decommodification, and the Conservative regime countries have median mortality and median decommodification) is statistically significant in both 1980 ($p < 0.005$) and 1998 ($p < 0.05$): Infant mortality is negatively correlated with decommodification in both 1980 (−0.497) and 1998 (−0.585). This suggests that IMR decreases as decommodification increases. Furthermore, the r^2 statistic suggests that around 25 per cent in 1980 and 35 per cent in 1998 of the variability in IMRs is accounted for by variability in labour market decommodification scores.

Commentary

Earlier in the paper, two inter-related hypotheses were outlined: (i) that a relationship exists between decommodification and health status; and (ii) that as decommodification varies between welfare states so will health status. On the one hand, the results have gone some way to confirm these hypotheses as a significant difference has been demonstrated between the decommodification scores and IMRs of the 'three worlds of welfare', and a moderate strength negative correlation between IMRs and decommodification was also identified. However, on the other hand, the correlation between IMR and decommodification does not mean that it can be concluded that decommodification causes variance in IMR. It is merely one of the various social and economic variables that have an influence on IMR. Indeed, the results suggest that other factors influence IMR, as the clear reductions in average IMR over time in all three of the welfare state regimes have been accompanied by moderate decreases in average decommodification scores. These decreases in IMR reflect the common increases in average living standards and GDP between 1980 and 1998, and the improvements in medical knowledge and health service technologies (OECD, 2003). Furthermore, whilst IMR varies between different types of welfare state, it cannot be assumed from research on this one indicator that all other indicators of population health status will similarly vary.

Nonetheless, the results do suggest that inequalities in health between countries reflect broader differences in their labour market decommodification scores. This is perhaps not surprising given the similarities between labour market decommodification and other, more widely established, indicators of class and income inequalities that have already been shown to be determinants of health status and international variance in health (Townsend *et al.* 1992; Wilkinson, 1996; Kawachi *et al.*, 1997; Mackenbach *et al.*, 1997; Acheson *et al.*, 1998). However, more research on how different welfare state arrangements contribute to health status, perhaps through examining the wider indicators of mortality and morbidity, is needed, if we are to more adequately and satisfactorily understand the complex interactions and use this to inform welfare state modelling.

There are also other important implications within the results for the 'three worlds of welfare' thesis and the debate that has emerged in its wake. The results show that welfare states vary in terms of an outcome other than labour market decommodification and that furthermore, labour market decommodification correlates with another important welfare state outcome. The results have also shown that not only does health status, in the form of infant mortality rates, vary across individual welfare states but that it also differs significantly between the three types of welfare state regime: the Liberal regimes have high infant mortality and low decommodification, the Social Democratic regime countries have low infant mortality and high decommodification, and the Conservative regime countries have median infant mortality and median decommodification. Furthermore, these differences are consistent across time as the results were significant in both 1980 and 1998.

In light of the results it is perhaps surprising that health status has not been explored before within the context of welfare state modelling. This is perhaps because much of the debate surrounding Esping-Andersen's influential typology (Leibfreid, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997; Kangas, 1994; Ragin, 1994; Shalev, 1996; Pitruzzello, 1999; Kasza, 2002; Alber, 1995; Abrahamson, 1999; Kautto, 2002; Lewis, 1992; Orloff, 1993; Borchost, 1994; Daly, 1994, O'Connor, 1993; Sainsbury, 1999) has

not taken its research agenda on comparing and categorising welfare states in terms of what they actually do any further. The results have confirmed that health status varies across the welfare states of the West (Mackenbach, 1999) and therefore that this is another important way in which what a welfare state actually does can be judged. It also suggests that the debate about Esping-Andersen and welfare state modelling has perhaps focused too much on the typology itself and not on the principles behind it.

Conclusion

This paper has returned to the basic principle of the 'three worlds of welfare' – that welfare states should be judged in terms of what they do rather than how much they spend or which services they provide. It has examined health status as a welfare state outcome in 1980 and 1998. It has shown that health status varies across welfare states and that there is a significant difference in terms of health (at least in terms of infant mortality rates) between the 'three worlds of welfare'. Furthermore, it has shown that there is a significant negative relationship between health outcomes and labour market decommodification. This suggests that, when judged in terms of outcomes – what they actually do – the 'three worlds of welfare' differ significantly from one another.

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